Pop Warner Little Scholars, Inc.

2025 PHYSICAL FITNESS & MEDICAL HISTORY FORM

Special Note: This form is to be dated after January 1, 2025 and then submitted to your LOCAL Pop Warner organization. No other forms are acceptable. Section II must be completed in its entirety ONLY by a Licensed State Examiner (medical doctor, nurse practitioner, etc.). Section II is modified or substituted ONLY to comply with local and/or state laws or medical practitioner regulations (i.e. the medical practice insists on its own form). In either case, Section I must still be filled out entirely and attached to any modified/substituted form.

Section I: FOR PARENT/GUARDIAN COMPLETION ONLY

Legal Name of Participant (must match birth certificate):

Last_____First_____Middle_____

Address_____City:_____State:_____Zip_____

Telephone No:_____Date of Birth:_____Male ☐ Female ☐
Name of Primary Medical Insurance Company:_____Policy Number:_____
Membership Number:_____Name of Primary Insured:_____
Does primary insured have Medicaid? Yes ☐ No ☐ Does primary insured have Medicare? Yes ☐ No ☐
Sport (check one): Cheer ☐ Dance ☐ Tackle ☐ Flag ☐

PARTICIPANT MEDICAL HISTORY

1. Are there any injuries requiring medical attention?	Yes ☐ No ☐
2. Are there any past surgeries or scheduled surgeries?	Yes ☐ No ☐
3. Is there any history of concussions and/or head injuries?	Yes ☐ No ☐
4. Is the participant currently under the care of a medical practitioner?	Yes ☐ No ☐
5. Is the participant currently taking any medications?	Yes ☐ No ☐
6. Does the participant have any allergies (penicillin, bee stings, etc)?	Yes ☐ No ☐
7. Does the participant have asthma/require the use of an inhaler?	Yes ☐ No ☐
8. Is the participant diabetic/require medication for diabetes?	Yes ☐ No ☐
9. Does the participant carry sickle cell trait/suffer from sickle cell disease?	Yes ☐ No ☐
10. Does the participant currently require medication?	Yes ☐ No ☐
11. Does/has the participant have/had seizures?	Yes ☐ No ☐
12. Does the participant wear glasses or contact lenses?	Yes ☐ No ☐
13. Does the participant wear a brace or other medical support device?	Yes ☐ No ☐
14. Does the participant have any other physical limitations or medical conditions?	Yes ☐ No ☐

If you answered yes to any of the above questions, please provide the question number and an explanation in the following space and/or attach to this form:

If you answered yes about concussions, provide the name of the doctor or qualified medical professional who cleared Participant for this activity:

I certify that this information is accurate. I understand that in the event of injury, illness or accident my child may not be cleared for participation. I acknowledge that it is my responsibility to inform my child's coach or organization official in writing if there is any change in my child's medical condition. I also understand it is my responsibility to obtain written permission from my child's physician on official medical stationary to resume participation after any and all injury, illness or accident.

Signature of Parent or Legal Guardian:_____
Print Name:_____
Relationship to Participant:_____

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2025 PHYSICAL FITNESS & MEDICAL HISTORY FORM

Section II: THIS SECTION MUST BE COMPLETED ONLY BY A LICENSED MEDICAL PROFESSIONAL ON OR AFTER JANUARY 1ST of the CURRENT CALENDAR YEAR.

This form must be completed in its entirety ONLY by a Licensed State Examiner (medical doctor, nurse practitioner, etc. – this may vary by state). NO other forms are acceptable unless Section II is modified or substituted ONLY to comply with local and/or state laws OR because of medical practitioner regulations (i.e. the medical practice insists on its own form).

Name of Participant:_____

(Please check the following if healthy or note otherwise):

Height:_____	Weight:_____	Eyes
Ears	Mouth:	Nose & Throat
Respiratory	Cardiovascular	Neurological
Musculoskeletal	Dermatological	BloodPressure

I hereby certify that I am a licensed state examiner and have examined the above named individual and understand that he/she will be participating in Pop Warner football, cheer or dance programs. I hereby attest that this individual is physically fit and has no medical condition which would prevent this individual from participating in Pop Warner activities for the 2024 season. I am therefore clearing this individual for athletic participation without limitation.

Please indicate medical profession (M.D., D.O., R.N., etc.)_____

Are you licensed in your state to perform physical examinations? YES ☐ NO ☐

Today's Date:_____

Please sign and fill out the following information OR place Official Medical Practice Stamp here:

Signature_____

Printed Name_____

Address_____City_____State_____Zip_____

Phone_____Fax:

Email_____(Optional)

Note to Pop Warner participants: If you're uploading this signed document directly into your participant profile within the Sports Connect roster system, please make sure each page includes a proper signature. It will not be accepted without signatures. Documents can be scanned as PDF files from your smartphone or tablet. **CLICK HERE** to learn how.